DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/29/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G223	A. BUILDING _____ B. WING _____	08/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	6217 16TH STREET, NW WASHINGTON, DC 20012

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W 000	INITIAL COMMENTS A recertification survey was conducted from August 11, 2011 through August 12, 2011, utilizing the fundamental survey process. A random sample of two clients was selected from a population of one female and three males with various levels of intellectual and developmental disabilities. The findings of the survey were based on observations at the group home and one program, interviews clients and staff and the review of clinical and administrative records, including incident reports.	W 000	Received 9/7/11 D[illegible] Health Health [illegible] Licensing Admin. Inter[illegible]e Care Facilities Divi. 899 North Capitol St., N.E. Washington, D.C. 20002	
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of investigations to the administrator or designated representative within five working days of the incidents, for two of the four clients residing in the facility. (Clients #1 and #3) The findings include: Review of the facility's incident and investigative reports on August 11, 2011, beginning at 9:16 a.m., revealed the following incidents and investigative reports:	W 156	In the future, the facility will report the results of all investigations to the administrator or designated representative within the required five working days of the incidents.	9/6/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese | TITLE: Program Director | (X6) DATE: 9/7/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 156	Continued From page 1 1. On August 3, 2011, at 6:00 a.m., staff discovered a bruise on Client #3's upper right arm. The staff notified the qualified intellectual disabilities professional (QIDP) at 7:00 a.m. The client was questioned and he indicated that "it occurred" at his day program. No further information was obtained from the client. The client was assessed by the licensed practical nurse. Review of the corresponding investigative report dated August 3, 2011, revealed that the investigation was completed. Further review of the investigative report revealed no evidence that the administrator had signed the results of the investigative report. An interview was conducted with the Incident Management Coordinator (IMC) on August 11, 2011, at 11:20 a.m., to ascertain information regarding the facility's incident management system. The IMC indicated that the serious reportable incidents do not require the Administrator's signature. 2. On May 28, 2011, at 7:50 a.m., Client #1 made an allegation of abuse. According to the incident report, the client was being assisted from her bed to participate in morning hygiene. The client swore at the staff and tried to punch the staff in the face. The staff blocked the punch with her hand, making contact with the client's hand. The client then made an allegation that the staff hit her. On August 11, 2011, at 10:00 a.m., review of the investigative report revealed that the investigation was completed on June 21, 2011, (twenty six	W 156	The QIDP will submit all investigative reports for serious reportable incidents to the Administrator for review and signature within 21 days.	9/6/11

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W 156	Continued From page 2 days after the incident occured). Interview with the incident management coordinator (IMC) on August 11, 2011, at 11:20 a.m., revealed that investigations for serious reportable incidents (incidents of allegations of abuse) can be completed within twenty one days. At the time of the survey, the facility failed to provide evidence the administrator was notified of the results of the investigative report.	W 156		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to ensure that the active treatment program was integrated, coordinated, and monitored, for two of two clients included in the sample. (Clients #1 and #2) The findings include: 1. Cross refer to W249. The facility's QIDP failed to ensure Client #2 received continuous active treatment in accordance with the interdisciplinary team (IDT) recommendations. 2. Cross refer to W212. The facility's QIDP failed to ensure that Client #1 who received psychotropic medications had a psychiatric assessment.	W 159	1. Client #2 will receive continuous active treatment. The complete documentation will be placed in the training book. 2. Psychiatric assessment for Client #1 was completed.	9/20/11 9/2/11

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W 159	Continued From page 3 3. Cross refer to W255. The facility's QIDP failed to ensure that each clients' individual program plans (IPP) were reviewed and revised once Client #1 successfully completed an objective identified in the IPP.	W 159	3. IPP for Client #1 has been reviewed and revised. New goal has been implemented.	9/12/11
W 212	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each client who received psychotropic medications had a psychiatric assessment, for one of the two clients in the sample. (Client #1) The finding includes: Observation of the evening medication administration on August 11, 2011, at 8:01 a.m., revealed Client #1 received Fluoxetine HCL and Risperidone F/C. Interview with the licensed practical nurse (LPN), after the medication administration, revealed that the medications were prescribed for behavior management. Review of the client's physicians orders (POS) dated August 2011, on August 11, 2011, at 11:50 a.m., revealed that the psychotropic medication were incorporated in a Behavior Support Plan (BSP) dated March 20, 2011, to address behaviors associated with physical and verbal aggression and non-compliance. Review of Client #1's medical evaluation dated	W 212	In the future, the primary care nurse will ensure annual psychiatric assessment is completed on time. The psychiatric assessment for Client #1 was completed.	9/2/11

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W 212	Continued From page 4 July 7, 2009, on May 26, 2010, at 3:00 p.m., revealed that the psychotropic medications were prescribed to address the client's behaviors associated with a diagnosis of schizophrenia. Interview with the registered nurse (RN) on August 11, 2011, at approximately 3:00 p.m., revealed that Client #1 is assessed by the psychiatrist monthly. After the RN reviewed the record, she confirmed that the client did not have a psychiatric assessment.	W 212		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility staff failed to ensure a client's Behavior Support Plan (BSP) was implemented consistently, for one of two clients included in the sample. (Client #2) The finding includes: The facility failed to ensure that Client #2's 1:1 staff remained in close proximity of the client as stipulated in his BSP, as evidenced below: On August 11, 2011, at 4:21 p.m., Client #2 was	W 249		

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W 249	Continued From page 5 observed sitting at the dining table tracing the letters of his first and last name. The evening 1:1 staff for Client #2 left the dining table and was observed preparing dinner in the kitchen. There was a wall observed separating the kitchen and the dining room area which made it difficult for the assigned 1:1 staff to visually see Client #2. The staff returned approximately one (1) minute later. At 4:24 p.m., Client #2 was left again at the dining table writing and tracing his name while his 1:1 staff was went back to the kitchen to continue preparing dinner. The 1:1 staff returned back to the dining table approximately 2 minutes later. Interview with the 1:1 staff on August 12, 2011, at approximately 9:20 a.m., revealed that Client #2 received 1:1 staffing 24 hours a day to manage his maladaptive behaviors and safety. (i.e. inappropriate touching of others and elopement). Further interview with Client #2's 1:1 staff acknowledged that she did not remain in close proximity of the client at all times as observed on August 11, 2011. On August 12, 2011, beginning at 9:20 a.m., review of Client #2's medical records revealed the client had diagnoses of pedophilia, depression with psychosis, and impulse control disorder. Review of Client #2's BSP dated July 6, 2011, on the same day at 1:06 p.m., confirmed the 1:1 staff's interview of the aforementioned maladaptive behaviors. Further review of Client #2's BSP revealed that the 1:1 staff must remain within arms reach at all times (i.e., home, community, and day program). The BSP also added that Client #1's 1:1 staffing was in place for safety precautions relative to sexually	W 249	All staff assigned to Client #2 have been scheduled for additional training on the BSP. There will be emphasis on staff remaining in close proximity to Client #2, within arms reach at all times.	9/23/11

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W 249	Continued From page 6 propositioning others.	W 249		
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record verification, the facility's qualified intellectual disabilities professional (QIDP) failed to ensure that each clients individual program plan (IPP) was reviewed and revised once the client had successfully completed an objective identified in the IPP, for one of the two clients in the sample. (Client #1) The finding includes: During dinner observations on August 11, 2011, at 5:28 p.m., Client #1 was observed removing her plate from the dining table and taking it to the kitchen sink, after verbal prompting from staff. Interview with the client at 5:35 p.m., indicated that she assists with household chores. Minutes later, in a face to face interview with the direct support staff, it was confirmed that the client will participate in household chores, when she is in a good mood. Review of Client #1's IPP dated May 6, 2011, on August 12, 2011, at approximately 11:00 a.m., revealed a program objective which stated, "After	W 255	The IPP for Client #1 is being reviewed and revised. In the future, the QIDP will monitor the progress and revise the IPP goal as needed.	9/23/11

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W 255	Continued From page 7 dinner and dessert, [the client] will be encouraged to follow simple auditory commands such as take your plate to the kitchen on 3/5 trials." Review of the data sheets from July 2010 through August 2011, revealed that the client met the established criteria.	W 255	Program objective for Client #1 is to encourage him to follow simple auditory commands such as take your plate to the kitchen on 3/5 trials will be removed from the IPP. A new goal/ objective will be developed and implemented. QIDP will monitor objectives monthly for progress and will revise criteria when met.	9/16/11
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility's nursing staff failed to provide routine laboratory testing as determined necessary by the primary care physician (PCP), for one of two clients included in the sample. (Client #2) The finding includes: The facility's nursing service failed to ensure Client #2's routine laboratory studies (Depakote) were obtained as recommended by the primary care physician, as evidenced below: On August 11, 2011, at 7:35 a.m., observation of the morning medication administration pass revealed that Client #2 was administered Depakote 500 mg by mouth. Review of Client #2's medical records on August 12, 2011, beginning 9:20 p.m., revealed a physician's order (PO's) dated August 2010.	W 325		

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W 325	Continued From page 8 According to the PO's, Client #2's depakote levels were to be monitored every three months. Subsequent review of his medical records revealed there were no laboratory studies done six months prior to the March 15, 2011, for depakote. Interview with the facility's registered nurse (RN) and further record review on August 12, 2011, at 10:25 a.m., confirmed that laboratory studies for depakote were not completed every three months as prescribed.	W 325	The nursing staff will ensure the Client #2's depakote levels are monitored every three months with laboratory studies as prescribed by the primary care physician. The primary nurse will review the physicians's order and schedule required laboratory test. The primary care nurse will receive additional training by the DON.	9/8/11 9/12/11
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure nursing services were provided in accordance with the needs for, three of of four clients residing in the facility. (Clients #1, #2, and #3) The findings include: 1. Cross refer to W325. The facility's nursing staff failed to ensure routine laboratory testing as determined necessary by the physician for Client #2. 2. Cross refer to W389. The facility nursing staff failed to ensure biological included appropriate accessory and instructions on pharmacy labels for Clients #1 and #3.	W 331	1. Cross reference W325 2. Cross reference W389	9/6/11 9/5/11
W 371	483.460(k)(4) DRUG ADMINISTRATION	W 371		

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W 371	Continued From page 9 The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations, interviews and the review of records, the facility failed to implement an effective system to ensure that each client participated in a self-medication training program as recommended by the interdisciplinary team, for one of the two clients in the sample (Client #1) The finding includes: Observation of the medication administration on August 11, 2011, at 8:01 a.m., revealed the licensed practical nurse (LPN) punched Client #1's medications into a medication cup. The client was then observed swallowing the medications and drinking the glass of water. The LPN went to the kitchen sink, washed his hands and documented the administration in the client's medication administration record (MAR). At no time did the LPN encourage the client to participate in the medication administration process. After the medication administration pass was completed, review of Client #1's MARs revealed a data collection sheet that was labeled "August 2011." The data sheet reflected a training program to include the following steps:	W 371	The nursing staff will be trained on how to encourage the individuals to participate in the Medication Administration Program.	9/7/11

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W 371	Continued From page 10 - Wash her hands; - Obtain and pour water; - Identify her [the client] on blister pack or bottle; - Identify Tegretol medication; - State purpose of Tegretol; and - Punch out medications from blister pack. Record review on August 12, 2011, at 10:00 a.m., revealed a self medication assessment dated June 23, 2011. According to the assessment, Client #1 was recommended for a self medication program. Minutes later, review of Client #1's individual program plan (IPP) dated May 6, 2011 revealed a program objective which stated, "[the client] will participate in self medication program with 100% independence. There was no evidence that the facility implemented Client #1's self-medication training program as recommended by the IDT.	W 371	Self Medication Administration Training is provided in the evening by the pm nurse. All clients will be given the opportunity to participate in self-medication administration training. The nursing staff will document progress on a daily basis.	9/12/11
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to implement and ensure that controlled substances were stored under double locks, for one of the four clients residing in the facility. (Client #4)	W 381		

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W 381	Continued From page 11 The finding includes: On August 11, 2011, at 7:35 a.m., the licensed practical nurse (LPN) was observed unlocking a file cabinet that contained the clients medications. At 7:54 a.m., he was observed retrieving a box from the cabinet containing the Clonazepam. The box did not have a lock on it. Seconds later, he was observed administering the Clonazepam to Client #4. Interview with the LPN, after the medication administration on August 11, 2011, at approximately 8:05 a.m., revealed that the nurse's were having difficulty with the lock on the medication box and therefore removed the lock. On August 12, 2011, at 2:36 p.m., the Clonazepam was in a box inside the medication cabinet under one lock. At 2:36 p.m., the registered nurse (RN) confirmed that the medication was stored using one lock. The RN indicated that the agency's policy revealed that controlled substances (Clonazepam) should be stored utilizing double locks. Review of the agency policy on August 12, 2011, at 2:45 p.m., confirmed the RN's statement.	W 381	The facility will purchase a box with a lock for all control substances. All control medications will be placed under double locks.	9/6/11
W 389	483.460(m)(1)(ii) DRUG LABELING Labeling for drugs and biologicals must include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable. This STANDARD is not met as evidenced by:	W 389		

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COMMUNITY MULTI SERVICES, INC	6217 16TH STREET, NW WASHINGTON, DC 20012

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W 389	Continued From page 12 Based on observation, staff interview and record review, the facility failed to ensure all drugs and biologicals included appropriate accessory and instructions on pharmacy labels, for two of the four clients residing in the facility. (Clients #1 and #3) The findings include: 1. During the medication administration observation on August 11, 2011, at 8:01 a.m., the licensed practical nurse (LPN) administered one drop of Dorzolamide Hydrochloride eye drops to Client #1's eyes. Review of the medication bottle revealed the client's name and the name of the medication was printed on the bottle. However, the bottle did not indicate any instructions for administration (number of drops or how often the medication should be administered). After the medication administration, an inquiry was made to the LPN to ascertain information regarding instructions on Client #1's medication (Dorzolamide) pharmacy label. The LPN revealed that there was no instructions on the eye drop bottle. She further indicated that the instructions were on Client #1's medication administration record. 2. Similarity, Client #3 did not have instructions on his pharmacy label as evidenced below: During the medication administration observation on August 11, 2011, at 7:47 a.m., it was revealed that the LPN administered Dorzolamide Hydrochloride eye drops to Client #3's eyes. Review of the medication bottle revealed the client's name and name of the medication was	W 389	In the future, the primary nurse will check all medications for appropriate medication instruction labels. Any medication with no appropriate label will be removed from the medication box. This will be done on a weekly basis.	9 /15/11

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W 389	Continued From page 13 printed on the bottle. However, the bottle did not indicate any instructions for administration (number of drops or how often the medication should be administered). After the medication administration, an inquiry was made to the LPN to ascertain information regarding instructions on Client #3's medication (Dorzolamide) pharmacy label. The LPN revealed that there was no instructions on the eye drop bottle. She further indicated that the instructions were on the client's medication administration record.	W 389		
W 391	483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing labels. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to remove medications from its use that had a worn label, for one of the two clients in the sample. (Client #1) The finding includes: On August 12, 2011, at 2:05 p.m., during the environmental inspection, a bottle of Beta-Val Lotion was observed in Client #2's personal hygiene kit. Further observation revealed that the bottle had a worn pharmacy label. According to the label, the only observed information was the Client #2's name. During the environmental inspection, the incident management coordinator confirmed that the bottle of Beta-Val Lotion had a worn label.	W 391	Cross reference W389	9/15/11

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W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on the interview and review of the fire drill records, the facility failed to conduct fire drills under varied conditions, for four of four clients residing in the facility. (Clients #1, #2, #3, and #4) The finding includes: Interview with the House Manager (HM) on August 11, 2011, at 11:41 a.m., revealed that the facility had at least five methods of egress (front door, back door, side door, side door on 3rd floor, and the basement door). Review of the facility's fire drill records on August 11, 2011, beginning at 11:43 a.m., revealed that most of the fire drills were conducted utilizing the front door, back door, and side door exits. Further review of the fire drill records revealed that the basement door exit was not used from September 2010 to present. At 12:15 p.m., the HM confirmed that the basement door exit was not utilized during the past year. There was no evidence on file at the time of survey to substantiate that all exits were used.	W 441	QIDP will ensure that all exits under which the fire drills are to be conducted are utilized including use of the basement door. Fire drills will be reviewed quarterly.	9/6/11

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I 000	INITIAL COMMENTS A licensure survey was conducted from August 11, 2011 through August 12, 2011. A sample of three residents was selected from a population of one female and three male residents with various intellectual and developmental disabilities. The findings of the survey were based on observations, interviews with residents and staff, one day program, as well as a review of resident and administrative records, including incident reports.	I 000		
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure adequate administrative support had been provided to effectively meet the needs, for two of two residents included in the sample. (Residents #1 and #2) The findings include: 1. Cross refer W193. The GHPID's QIDP failed to ensure 1:1 staff demonstrated competency in implementing Resident #2's behavior support plan. 2. Cross refer to W249. The GHPID's QIDP failed to ensure Resident #2 received continuous active treatment in accordance with the interdisciplinary team (IDT) recommendations.	I 180	Cross reference W249	9/23/11

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Laurence C. Reese — Program Director — 9/7/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review and interview, the group home for persons with intellectual disabilities (GHPID) failed to ensure eleven out of sixteen employees were provided the opportunity to annually review their written job descriptions as required by this section. (Employees #1, #4, #5, #6, #8, #9, #10, #11, #13, #14, and #15) The finding includes: On August 12, 2011, beginning at 11:58 p.m., interview with the house manager (HM) and review of the personnel files revealed the GHPID's failed to provide evidence that the facility had discussed the contents of job descriptions, for eleven out of sixteen employees. (Employees #1, #4, #5, #6, #8, #9, #10, #11, #13, #14, and #15)	I 203	The contents of the job descriptions for employees #1, #4, #5, #6, #8, #9,#10, #11, #13, #14 and #15 will be reviewed and discussed with each employee respectively as required by section: 3509.3 Personnel Policies.	9/23/11
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the Group	I 206		

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I 206	Continued From page 2 Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that one of the eight nurses (Nurse #1) and one of the nine consultants (Pharmacist) had current health certificates. The finding includes: On August 12, 2011, beginning at 11:00 a.m., review of the personnel records revealed the GHPID failed to have evidence of current health certificates for one of the eight nurses and one of the nine consultants. The staff confirmed that one nurse and the pharmacist were without current health certificates in their personnel files.	I 206	Nurse #1's health certificate will be placed on file. The pharmacist's current health certificate will be placed on file. In the future, the QIDP will check personnel records on a monthly basis.	9/8/11 9/15/11
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to have on file for review, current training in cardiopulmonary resuscitation (CPR), for one of sixteen employees. (Employee #5) The finding includes: The GHPID failed to ensure a current CPR certification was on file for Employee #5. This was confirmed by the house manager (HM) at approximately 1:00 p.m., who looked through	I 227	CPR for employee #5 will be placed in their personnel record. QIDP will monitor files quarterly for current CPR certification.	8/21/11

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I 227	Continued From page 3 Employee #5's personal files.	I 227		
I 399	3520.2(i) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (i) Speech and language therapy; and... This Statute is not met as evidenced by: Based on interview and record review, the GHPID failed to ensure that a copy of professional credentials was maintained for each individual providing professional services at the GHPID, as required by District of Columbia law, in the following disciplines or area: (i) Speech and Language Therapy. The finding is: Review of the personnel records on August 12, 2011, beginning at 11:00 a.m., revealed that a current professional license was not available for the Speech Language Therapist. At approximately 12:30 p.m., the GHPID's qualified intellectual disabilities professional confirmed that the license/professional credentialing for the Speech Language Therapist was not available for review.	I 399	A current professional license will be obtained from the Speech Pathologist.	9/16/11

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I 399	Continued From page 4 On August 15, 2011, at 11:00 a.m., a search of professional licensing records online revealed no evidence that the consulting Speech Language Therapist was licensed to practice in the District of Columbia, in accordance with: Title 3, Chapter 12 of the District of Columbia Official Code SUBCHAPTER V. LICENSING, REGISTRATION, OR CERTIFICATION OF HEALTH PROFESSIONALS § 3-1205.01. License, registration, or certification required. (a) A license issued pursuant to this chapter is required to practice medicine, acupuncture, chiropractic, registered nursing, practical nursing, dentistry, dental hygiene, dietetics, marriage and family therapy, massage therapy, naturopathic medicine, nutrition, nursing home administration, occupational therapy, optometry, pharmaceutical detailing, pharmacy, physical therapy, podiatry, psychology, social work, professional counseling, audiology, speech-language pathology, respiratory care, advanced practice addiction counseling, or to practice as an anesthesiologist assistant, physician assistant, physical therapy assistant, polysomnographic technologist, occupational therapy assistant, or surgical assistant in the District, except as otherwise provided in this chapter. No additional information was presented before the survey ended 24 hours later.	I 399		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment	I 401		

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I 401	Continued From page 5 services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure professional services that included both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident for two of two residents included in the sample. (Residents #1 and #2) The findings include: 1. The GHPID's nursing service failed to ensure Resident #2's routine laboratory studies (Depakote) were obtained as recommended by the primary care physician, as evidenced below: On August 11, 2011, at 7:35 a.m., observation of the morning medication administration pass revealed that Resident #2 was administered Depakote 500 mg by mouth. Review of Resident #2's medical records on August 12, 2011, beginning 9:20 p.m., revealed a physician's order (PO's) dated August 2010. According to the PO's, Resident #2's depakote levels were to be monitored every three months. Subsequent review of his medical records revealed there were no laboratory studies done six months prior to the March 15, 2011, for depakote. Interview with the GHPID's registered nurse (RN) and further record review on August 12, 2011, at	I 401	Cross reference W325	9/6/11

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I 401	Continued From page 6 10:25 a.m., confirmed that laboratory studies for depakote were not completed every three months as prescribed. 2. The facility failed to ensure that each residents who received psychotropic medications had a psychiatric assessment, for Resident #1 Observation of the evening medication administration on August 11, 2011, at 8:01 a.m., revealed Resident #1 received Fluoxetine HCL and Risperidone F/C. Interview with the licensed practical nurse (LPN), after the medication administration, revealed that the medications were prescribed for behavior management. Review of the resident's physicians orders (POS) dated August 2011, on August 11, 2011, at 11:50 a.m., revealed that the psychotropic medications were incorporated in a Behavior Support Plan (BSP) dated March 20, 2011, to address behaviors associated with physical and verbal aggression and non-compliance. Review of Resident #1's medical evaluation dated July 7, 2009, on May 26, 2011, at 3:00 p.m., revealed that the psychotropic medications were prescribed to address the resident's behaviors associated with a diagnosis of schizophrenia. Interview with the registered nurse (RN) on August 11, 2010, at approximately 3:00 p.m., revealed that Resident #1 is assessed by the psychiatrist monthly. After the RN reviewed the record, she confirmed that the resident did not have a psychiatric assessment.	I 401	Cross reference W212 Cross reference W212	9/2/11 9/2/11
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with	I 422		

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I 422	Continued From page 7 the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that residents' training objectives were implemented in accordance with their Individual Support Plan (ISP), for one of two residents included in the sample. (Resident #2) The finding includes: The GHPID failed to ensure that Resident #2's 1:1 staff remained in close proximity of the resident as stipulated in his BSP, as evidenced below: On August 11, 2011, at 4:21 p.m., Resident #2 was observed sitting at the dining table tracing the letters of his first and last name. The evening 1:1 staff for Resident #2 left the dining table and was observed preparing dinner in the kitchen. The staff returned approximately one (1) minute later. At 4:24 p.m., Resident #2 was left again at the dining table writing and tracing his name while his 1:1 staff was went back to the kitchen to continue preparing dinner. The 1:1 staff returned back to the dining table approximately 2 minutes later. Interview with the 1:1 staff on August 12, 2011, at approximately 9:20 a.m., revealed that Resident #2 received 1:1 staffing 24 hours a day to manage his maladaptive behaviors and safety. (i.e. inappropriate touching of others and elopement). Further interview with Resident #2's 1:1 staff acknowledged that she did not remain in close proximity of the client at all times as observed on August 11, 2011.	I 422	Cross reference W249	9/23/11

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I 422	Continued From page 8 On August 12, 2011, beginning at 9:20 a.m., review of Resident #2's medical records revealed the resident had diagnoses of pedophilia, depression with psychosis, and impulse control disorder. Review of Resident #2's BSP dated July 6, 2011, on the same day at 1:06 p.m., confirmed the 1:1 staff's interview of the aforementioned maladaptive behaviors. Further review of Resident #2's BSP revealed that the 1:1 staff must remain within arms reach at all times (i.e., home, community, and day program). The BSP also added that Resident #1's 1:1 staffing was in place for safety precautions relative to sexually propositioning others.	I 422		
I 424	3521.5(a) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client: (a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan; This Statute is not met as evidenced by: Based on staff interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to review and revise the Individual Program Plan (IPP) once the residents had successfully completed an objective identified in the IPP, for one of the two residents in the sample. (Resident #2) The finding includes: During dinner observations on August 11, 2011,	I 424	Cross reference W159	9/12/11

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I 424	Continued From page 9 at 5:28 p.m., Resident #1 was observed removing her plate from the dining table and taking it to the kitchen sink, after verbal prompting from staff. Interview with the resident at 5:35 p.m., indicated that she assists with household chores. Minutes later, in a face to face interview with the direct support staff confirmed that the resident will participate in household chores, when she is in a "good mood." Review of Resident #1's IPP dated May 6, 2011, on August 12, 2011, at approximately 11:00 a.m., revealed a program objective which stated, "After dinner and dessert, [the resident] will be encouraged to follow simple auditory commands such as take your plate to the kitchen on 3/5 trials." Review of the data sheets from July 2010 through August 2011, revealed that the resident met the established criteria.	I 424	Cross reference W255	9/23/11
I 436	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by: Based on observations, interviews and the review of records, the Group Home for Mentally Retarded Persons (GHMRP) failed to implement an effective system to ensure that each resident participated in a self-medication training program, for one of the two residents in the sample. (Resident #1)	I 436	Cross reference W371	9/7/11

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 436	Continued From page 10 The finding includes: Observation of the medication administration on August 11, 2011, at 8:01 a.m., revealed the licensed practical nurse (LPN) punched Resident #1's medications into a medication cup. The resident was then observed swallowing the medications and drinking the glass of water. The LPN went to the kitchen sink, washed his hands and documented the administration in the resident's medication administration record (MAR). At no time did the LPN encourage the resident to participate in the medication administration process. After the medication administration pass was completed, review of Resident #1's MARs revealed a data collection sheet that was labeled "August 2011." The data sheet reflected a training program to include the following steps: - Wash her hands; - Obtain and pour water; - Identify her [the resident] on blister pack or bottle; - Identify Tegretol medication; - State purpose of Tegretol; and - Punch out medications from blister pack. Record review on August 12, 2011, at 10:00 a.m., revealed a self medication assessment dated June 23, 2011. According to the assessment, Resident #1 was recommended for a self medication program. Minutes later, review of Resident #1's individual program plan (IPP) dated	I 436	Cross reference W371	9/12/11

PRINTED: 08/29/2011
FORM APPROVED

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G223	A. BUILDING _____ B. WING _____	08/12/2011

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I 436	Continued From page 11 May 6, 2011 revealed a program objective which stated, "[the resident] will participate in self medication program with 100% independence. There was no evidence that the facility implemented Resident #1's self-medication training program as recommended by the IDT.	I 436		
I 484	3522.11 MEDICATIONS Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Persons with Intellectually Disabilities (GHPID) nurse failed to remove medications with worn labels from use, for one of the two residents in the sample. (Resident #1) The findings include: On August 12, 2011, at 2:05 p.m., during the environmental inspection, a bottle of Beta-Val Lotion was observed in Resident #2's personal hygiene kit. Further observation revealed that the bottle had a worn pharmacy label. According to the label, the only observed information was the Resident #2's name. During the environmental inspection, the incident management coordinator confirmed that the bottle of Beta-Val Lotion had a worn label.	I 484	Cross reference W389	9/15/11